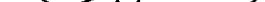


MISCELLANEOUS

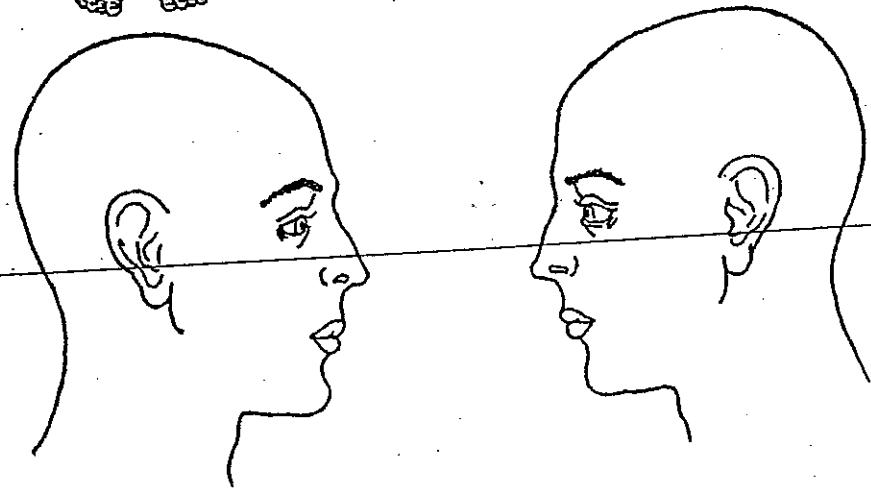
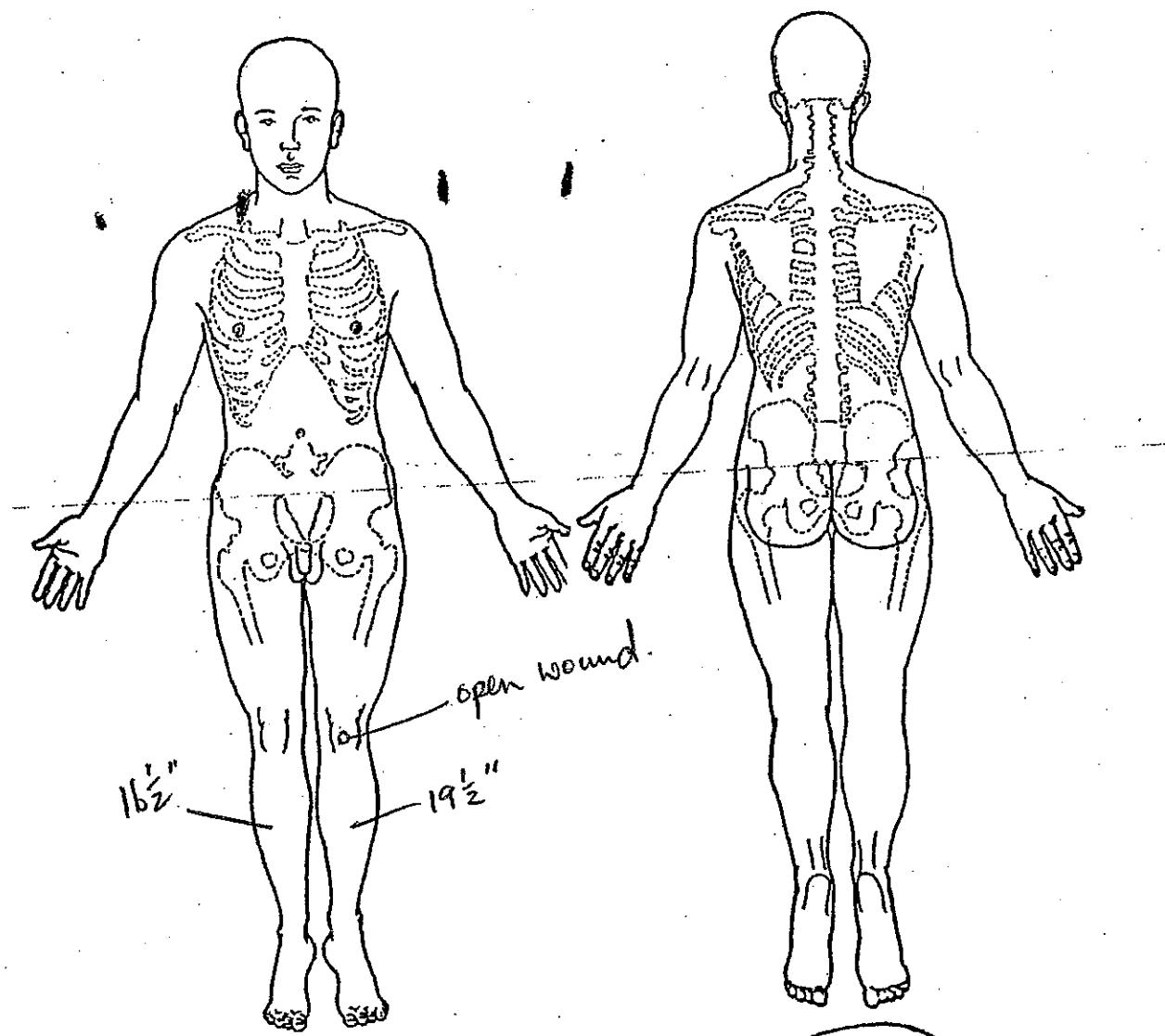
Nursing Assessment Protocol

Nurse's Signature and stamp: 

100001

ANATOMICAL FIGURE

INITIAL ALL ENTRIES ON THIS FORM, SIGN AND DATE



000002

INMATE NAME:	Redden, Emanuel	ID #:	RACE:	DOB:
COMPLETED BY:	B. Cameron	TITLE:	2PN	DATE: 7-24-04
				TIME: 1040

INMATE NAME

NUMBER: Reddick, EMANUEL (medium)

ORDERED BY: Dr. A. M. Edwards

ORDER:

DATE ORDERED: 7/24/4

DATE EXPIRES: 8/4/44

C | CORRECTIONAL

M MEDICAL

**CALL MD IF SBP>190mmHg OR IF DBP>110 OR ANY COMPLAINTS OF HA, CP, SOB ETC.
ALL BP's SHOULD BE TAKEN WHILE PATIENT IS SITTING, AFTER 2 MINUTES OF REST.
MR 1008**

300004



Infirmary Intake Form

Nursing Assessment Protocol

Use Progress Notes for Additional Documentation

Inmate Name: <u>Redden, Emanuel</u>	Date: <u>7-36-04</u>
Number: <u>1234567</u>	Time: <u>1100</u>
Gender: <u>Male</u>	Medications: <u>/ MAR</u>
Facility: <u>SCI</u>	Medications: <u></u>
Allergies: <u>PCN</u>	Appearance: <input type="checkbox"/> No Distress <input checked="" type="checkbox"/> Minimal Distress <input type="checkbox"/> Acute Distress

SUBJECTIVE: Chief Complaint: R/o open wound LT lower leg

Symptoms:

<input type="checkbox"/> Delayed Verbal Response	<input type="checkbox"/> Delayed Motor Response
<input type="checkbox"/> Uncoordinated Movement	<input type="checkbox"/> Bleeding / Bruising Behind Ears
<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Confusion
<input type="checkbox"/> Pain: Where: _____	<input type="checkbox"/> Lack of Attention
	<input type="checkbox"/> Memory Loss
	<input type="checkbox"/> Loss of Balance
	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Drowsiness
	<input type="checkbox"/> Decreased LOC
	<input type="checkbox"/> Seizures

Scale 1 2 3 4 5

OBJECTIVE:

Temp: 97 Pulse: 62 Resp: 20 B/P: 143/82 Pulse Ox: _____ WT: _____ Finger Stick: _____

Evidence of trauma
Head: _____

Torso: (1) knee

Extremities: LT lower leg

Wounds

Head: _____

Torso: (1) knee

Extremities: LT knee

Deformities

Head: _____

Torso: N/A

Extremities: _____

Mark and Describe on Diagram			
Right	Left		
Left	Right		

ASSESSMENT:

Critical – Immediate Referral Local Emergency Department

Stable - may house in infirmary

Other: _____

Nurse's Signature and Stamp: B. Cameron Ken Time: 1100

000005



Infirmary Admission Provider Order Sheet

Date: 7-26-04 Facility: SCC Infir Time: 1145

Inmate Name: Redden, Emanuel Inmate Number: ██████████

Allergies: PCN

1. Admit to: Medical infirmary or

2. Diagnosis: Open wound, ██████████

1.

2.

3.

3. Allergies: PCN

1.

2.

3.

4. Diet (circle): NPO Liquid Diet Regular Other: _____

5. IV Fluids as follows _____

6. Vital signs: q 2 hrs q 4 hrs q 8 hrs

7. Neuro checks: q 2 hrs q 4 hrs q 8 hrs N/A

8. Medications:

1. Erythromycin 500 mg PO QID x 8 days
2. Motrin 1800 mg PO tid x 2 wks
3. Colace 100 mg t BID PRN x 2 wks
4. ██████████
5. ██████████

9. Parameters:

Please call the physician provider if: Pulse Ox is greater than 120 or less than or equal to 50; Systolic BP is greater than 190 or less than 110; Diastolic BP is greater than 105 or less than 50; Pulse Ox is less than 92% *and ankles*

10. Treatments: ↑ Dreg in bed. measure calves QD X 1 wk

02 at ██████████

Dressing changes: See below

Nebulizer treatment: ██████████

Other: warm compress to leg & knee
Bid, cleanse wound & dress and
Q-tip, Pack &

Provider Signature & Stamp: Frances Molinore, FNP

Frances Molinore, FNP

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE
2/26/04	1159	INF	Admitted to infirmary. Legs elevated.
1300	501	SCI	Orders reviewed. <u>Dynamic</u>
2/26/04	1800	Inf NSG SCI	S. I'm feeling fine. O. VSS wNL, afebrile. Serosanguinous Drainage to bandage below (1) knee, size of quarter. No puss present. Cleared purple wound & NSS using sterile technique & packed wound in iodophore gauze. Covered in sterile 4x4. Tolerated procedure well. A. Altered skin integrity P. Continue in wound care BID, administer Abx, VSS, ↑ legs & warm compresses.
			<u>Susan Wallace, RN</u>
2/27/04	0530	NSG	A & O X 3 VSS. (R) calf was 16 1/2" & (L) calf 18". Ambulating well. Tolerating po. No clO pain. <u>Dynamic</u>
2/27/04	0530	NSG	24 hour chart check done. <u>Dynamic</u>
2/27/04		SCI INF	S - slept well. No constipation. (D) Knee swelling going down. O - aeo. Skin wNL. Lungs clear. RRR (L) calf 40cm, (R) calf 37cm. ↓ warmth off (L) leg but warmer than (R) leg (L) calf soft. Humans veg. Deep breaths & flexion/extension encouraged g 1/2 hr. PP & Post tibial pulses t2. (L) Danco edema. Bandage to (L)

NAME-Last

First

Middle

Attending Physician

Record No.

Room/Bed

Jordan, Emanuel

SCI

INTERDISCIPLINARY PROGRESS NOTES

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE		
	7/24 1800		Knee is bright red blood.		
	7/24 1800		A- S1P injury @ knee - wound		
	7/24 1800		P- Cont previous orders.		
	7/24 1800		E mom 30cc po QD x 1 wk.		
	7/24 1800		G. Morthole FNP Frances Morthole, FNP		
7/27/04	1800	INF. NSQ	S. "The swelling has gone down now"		
			Inf. O. (L) knee dressing prior to changing		
			had quartersize serosanguinous drainage		
			No purulent drainage on 10ds phone		
			gauze packing - serosanguinous only		
			Wound cleansed & repacked - (+) pedal		
			pulse. - Warm to touch (L) knee constipation		
			A. Aberration in skin integrity Pot'l		
			for infection.		
			P. Cont 0c antibiotics MOM 30cc po		
			given this AM - effective -		
			Jill Mosser RN JILL MOSSER, RN		
7/27/04	1800	INF. NSQ	S: "I'm doing alright"		
			O: VSS. AF. (L) knee dsq removed. Time - size		
			bloody serous drg. Clean S S/S of infection.		
			Warm compress x 15 min. Repack w/ 1/4" 10ds/10cc		
			packing strip w/ 5-6". 4x4 applied n		
			top w/ elastic retainer to secure drg.		
			Actual size of wound n 1/4" diameter. Cuff C/H ↓		
			A: Alt. Skin integrity. Potential 1/2 infection.		
			P: Admin. Antibiotic/orden. Drg DRSD. Eval. later.		

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE
7/26/04	0600	NSF	7/5/04 x 3. NSS. No Cto pain this am. Tolerating po. Ambulating 50' difficult. Bruised leg
7/28/04	0600	NSC	24 hour Chart check due: <i>[Signature]</i>
7/28/04	0830	PT	50" I did not sleep at all last night. MTF Dogs were barking, TVs yelling, my light was left on all night.
			D 1.5. stable, Afibrile. A+013, keeps near b.l. left leg warm to touch C knee cap and above. Wound opened 1cm by 2cm deep. Area cleaned Parted with gauze, covered 4x4, st. 16
			Afternoon left leg pain.
			B minor edema, drainage left foot & leg. Monitor temp. Keep leg elevated. T/F. <i>[Signature]</i>
7/29/04	MD	S:	Apparently leg is much improved
		D:	Pocket pulled from significant hole in front of knee. By Wazantha R.D.
		R:	Cellulitis.
		P:	Continue cream.
			<i>RTG Rm</i>

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
Reddick	Emmanuel				SCI

INTERDISCIPLINARY PROGRESS NOTES

NAME-Last		First	Middle	Attending Physician	Record No.	Room/Bed
DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE			
1/22/01	2300	Nsg scr	S. "How much longer do I have to stay here?"			
		Int.	<p>① Showered this evening. ② knee warmer than ② knee. ① knee & packed wound - small amt serosanguinous drainage - no peritoneal drainage. ④ pedal pulses.</p> <p>① Wound cleansed & VSS & re-packed - No ④ pain. - states numbness around ① knee wound. Afebrile.</p> <p>A. Alteration in skin integrity</p> <p>P. Can't to do warm compresses BID & dressing to ② knee -</p> <p><i>Jill Mosser, RN</i></p>			
1/23/01	0600	nurse scr	<p>⑤ "Want my knee to be O.K." -</p> <p>⑥ VSS Afebrile. Leg warm to touch. Dry DLT. Pedal pulse. No ④ pain. Edema mild.</p> <p>⑦ Alt in comfort ③ HR for infection</p> <p>⑧ Antx. Rest. Dry S's.</p> <p>⑨ Clean dress. Elevate.</p> <p><i>Amy Munson, RN</i></p>			
<p>34° Chart, <i>Jm</i></p>						

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE
7/29/04	0900	NSG/S	"I'm finding it difficult to sleep at night c all the noise."
		O.	LLE, calf measures 16 $\frac{3}{4}$ ". Warm to touch, + pedal pulse. Upper thigh warmer to touch, than lower extremity. Knee draining bloody drainage, packed c sterile dressing and covered c dry dressing. No further complaint of pain to knee.
		A.	Alteration in comfort R/T knee pain.
		P.	Monitor for S/S infection. — B. Cameron, LPN
7/29/04	1600	STT -0030	(S) "I'm feeling Okay." — (P) Had quiet evening, in bed resting c POB 7. No 9/10 pain to knee. Scant amt. of bloody drainage noted on leg. No tunneling noted to wound, No purulent drainage noted. VS 152/91, 96 $^{\circ}$ F, 65-20. — (P) O Will continue to monitor. — C. Collins
7/30/04	0500		S) Alert & Oriented to time (P) Vitals: S 188, T 96.6, R 20, H 63, P 98% (A) Altecet in sleep patter (C) Continue to monitor in evening. — P. H. S. —

E-Last

First

Middle

Attending Physician

Record No.

Room/Bed

Redden Emanuel

SCI

INTERDISCIPLINARY PROGRESS NOTES

NAME-Last		First	Middle	Attending Physician	Record No.	Room/Bed
DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE			
1/30/04	0900	SCI NSG	S. I don't think it's really significant. O. VSS WNL. AD 2 3. No c/o pain. (L) calf 16 1/3" (R) calf 16 1/3" (S) small amount of serosanguinous drainage & dry. A. Packed wound & ~4" iodo from 1/4" gauge. O S/s of purulent drainage. P. Alt in comfort related to cellulitis. R. Cont & current tx. Monitor for s/s of infection.	<u>Victoria Hayden, LPN</u>		
2/30/04	MD	S. leg swelling down O. skin no longer hot Krysma's much better in knee. A. Cellulitis resolving P. Continue current rx.	<u>RF/SWMM</u>			
2/30/04	2200	SCI NSG NP	S. "I'm feeling a lot better!" O. VSS WNL. Decreased pain (L) calf 17", (R) unaffected calf 16". Tolerated dry 1 & packing & c/o pain, only very slight discomfort observed a/f/b guarding & hard. Wound care done per MD protocol. O purulent drainage. Warm, moist socks x1. A. Alt in comfort P. Cont. & wound care, warm moist socks and abx per MD's protocol. Subalone RN	<u>Subalone RN</u>		
3/1/04 (04)	NSG	SCI	240 Chart, /done/ ~ 1/2 full	<u>Subalone RN</u>		
			S. Yea I slept well, but it's cold (O) VSS, AD 0 NO C/o discomfort. (A) Alt in comfort (P) Cont to monitor. Subalone RN	<u>Subalone RN</u>		

INTERDISCIPLINARY PROGRESS NOTES

DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE
7/31/04 1100		SCI Neg	<p>S: "I feel alright." Jill</p> <p>O: A+ O² x 4. VSS. Calves + ankles measured + recorded on flowsheet. LKNE wound cleansed, packed, dressed per MD order. No tunnelling of wound. No purulent drainage. Jill</p> <p>A: Impaired skin integrity, HR infection Jill</p> <p>P: Cont & POC Jill</p>
7/31/04 2200		NSG SCF	<p>S: "Monday I'll be getting out of here." Jill</p> <p>O: Alert + oriented x 3 LLE elevated - L knee wound cleansed & VSS + repacked. No drainage. No purulent drainage - No odor. Cereosanguinous drainage. Pedal pulses warm moist compressed to LLE x 1. Jill</p> <p>A: Impaired skin integrity Jill</p> <p>P: Cont & dressing changes + po antibiotics. Jill</p>
8/1/04 0030		NSG SCF	<p>2 LLE Chart / done - Whitley, LP</p> <p>I'm resting quietly w/ eyes closed - Whitley, LP</p> <p>S: I am going to get out of here tomorrow Whitley, LP</p> <p>VSS A&O, Eyes P+ I ambulates ss quadrip. Whitley, LP</p> <p>A: Impaired skin int. Whitley, LP</p> <p>P: Cont w/ POC, monitor for s/s of infection. Whitley, LP</p>

ME-Last

Radden

First

Emanuel

Middle

Attending Physician

Record No.

Room/Bed

SCI

INTERDISCIPLINARY PROGRESS NOTES

NAME—Last

First

Middle

Attending Physician

Record No. _____

Room/Bed

5c1

DATE TIME DISCIPLINE

NOTES SHOULD BE SIGNED WITH NAME AND TITLE

8/1/04	9A	NSG	S: "I'm getting out tomorrow."
		O:	VSS serosanguinous drainage on bandage. No pain at site. alert or oriented.
		A:	Alteration in skin integrity.
		P:	Continue dressing changes, warm compresses & monitoring. <u>Coughhead, RN</u>
8/1/04	2100	NSG SCT	S: "I'm so bored & nothing to read"
		INF:	O: Small amount bloody drainage from ① knee wound - Repacked - No purulent drainage. Atelocile. ^{warm} moist compresses applied -
		A:	Alteration in skin integrity
		P:	Cont & dress. <u>Jill Mosser, RN</u>
8/2/04	100	SCT	240 Chart done - <u>Skowles, LPN</u>
		INF:	I'm resting quietly & eyes closed I'm ready to get out of here
		O:	VSS ADL ambulating 85% guarding Alt 1/4 circulation
		D:	Cont to monitor - measure legs
			<u>Skowles, LPN</u>

INTERDISCIPLINARY PROGRESS NOTES

000014

INTERDISCIPLINARY PROGRESS NOTES

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
Redden Emanuel					

DATE	TIME	DISCIPLINE	NOTES SHOULD BE SIGNED WITH NAME AND TITLE		
4/6/04	04		Motrin 800 mg po tid x 2 wks		
4/6/04	06		Colace 100mg po Bid PRN		
4/6/04	07		↑ D1eg		
4/6/04	08		Measure cap/ankle. blot & warm compress D1eg Bid		
4/6/04	09		Dose 1 Bid & NSS - use Q+P in wound, pack in plain 1/4" gauze and cover in 2x2's		
4/6/04	10		VS q 4hr, adm to inf.		
4/6/04	11		Gymnophol 4WP Frances Morthole, FNP		
7/9/04	0915	SCI	Key of abdomen: tenderness & rebound with		
7/9/04	0915	SCI	Considerable rectus spasm, firm & faint		
7/9/04	0915	SCI	Spine: normal	JKR	mm
7/9/04	0915	SCI	8-10-04 0915 247 lbs 128 72 65 18 97% SUE SCHAPPEL R		
7/9/04	0915	SCI	8-10-04 0915 S - D knee wound better	SUE SCHAPPEL, RN	
7/9/04	0915	SCI	Spider bite 3 days		
7/9/04	0915	SCI	0 - D knee contusion and greenish drainage		
7/9/04	0915	SCI	D packing in wound, hole smaller than inside wound. Tissue pink in		
7/9/04	0915	SCI	wound - cleaned & packed in 1/4"		
7/9/04	0915	SCI	packing strip - covered in gauze & nothing. BS x 4 quadr - sluggish		
7/9/04	0915	SCI	Spider bite (D) Soreness reduced		
7/9/04	0915	SCI	& edema down.		

BLOOD PRESSURE FLOW SHEET

INMATE NAME: Redden Emanuel

NUMBER: 100-00000000

ORDERED BY: F. Morthole Jr.

ORDER: V.5 940

DATE ORDERED: 7.26.04

DATE EXPIRES: _____

**CALL MD IF SBP>190mmHg OR IF DBP>110 OR ANY COMPLAINTS OF HA, CP, SOB ETC.
ALL BP'S SHOULD BE TAKEN WHILE PATIENT IS SITTING, AFTER 2 MINUTES OF REST.
MR 1008**

D00017

PHYSICIAN'S ORDER SHEET**ORDERS:**

Another brand or a generically equivalent product (identical in dosage form and content of active ingredient) may be administered unless checked.



WRITE OR IMPRINT
PATIENT INFORMATION BELOW

START

mom 30cc po qd x 7d PRN

*Noted
7/29/04*

Frances Morthole, FNP

0810

PROVIDER'S SIGNATURE

DATE/TIME

START NEW ORDERS BELOW

START

① *Key to home*

Noted B. Cameron LPN 7.29.04 1250

Brenda Cameron, LPN

PROVIDER'S SIGNATURE

DATE/TIME

START NEW ORDERS BELOW

START

*Release to gen pop
See next order sheet*

Noted B. Cameron LPN 8.2.04

Frances Morthole, FNP

0915

PROVIDER'S SIGNATURE

Morthole, FNP

DATE/TIME

8.2.04

000018

NAME
Roddon, EmanuelALLERGIES
P.S.C.

ID

DOB

6-21-50

PHYSICIAN'S ORDERS

PHYSICIAN'S ORDER SHEET

ORDERS: Another brand or a generically equivalent product identical in dosage form and content of active ingredient may be administered unless checked.

WRITE OR IMPRINT
PATIENT INFORMATION BELOW

START

Cont Erythromycin 500mg QID x 1wk
Elevate R leg
Bottom Bunk
Keep dry clean & dry
Measure CR & R calves QD x 3 days
then PRN
2x2 w-o dress 1 B.i.d x 3 days then
so till healed
Flu (wk 2 me
Olc warm compresses

given
be

NAME Roderick, Frances
ALLERGIES PCN

PROVIDER'S SIGNATURE: Frances Morthole, FNP DATE/TIME: 0920

START NEW ORDERS BELOW

START

X-ray R knee done
Cont Amoxi 800mg P.O. tid x 2w S. given
Noted B. Cameron 4/4 8-9-04 0930

IP
DB C-2150

Frances Morthole, FNP

0920

PROVIDER'S SIGNATURE

DATE/TIME

START NEW ORDERS BELOW

START

PROVIDER'S SIGNATURE

0920
DATE/TIME



Mid-Delaware Imaging

Sussex Correctional Institute
Route 113, North
Georgetown, DE 19947

NAME: EMANUEL REDDEN

DOB: [REDACTED]

DOS: [REDACTED]

DATE SUBMITTED: 8/2/04

SBI: [REDACTED]

CLINICAL INFORMATION: PAIN.

LT KNEE:

Examination of left knee shows moderate to severe osteoarthritis with considerable reactive spur formation and joint space narrowing. There is no joint effusion. There is no fracture or bone destruction.

MP/par



Mahendra Parikh, M.D.

A handwritten signature in black ink, appearing to read 'Mahendra Parikh, M.D.' followed by a date 'Aug 6 2004'.

710 South Queen Street
Dover, Delaware 19904
302-734-9888

000020

Name: Redden, Emanuel SBI# [REDACTED] DOB [REDACTED] Sex: Male Race: Black

Date: 8.2.04 Time: 0930 From: Infirmary
Method: Ambulatory: Stretcher: Ambulance:

Escorted By: DOC

Discharge/Transfer ordered by: DR BURNS Receiving facility contacted: Yes No
Accompanying patient: Outpatient Medical Records Discharge Summary Prosthetic Devices
(specify) _____

Vital Signs Prior to Discharge: T _____ P _____ R _____ BP _____

Patient Condition at time of discharge:

Stable

Is patient experiencing discomfort (pain, respiratory, muscle/skeletal, etc.)? _____

denies

Discharge Diet: Regular PPD Date: (+) PPD Results: MN:

Condition of Skin	Yes	No	Location/Description
Good Condition	<input checked="" type="checkbox"/>		
Rash		<input checked="" type="checkbox"/>	
Reddened Areas		<input checked="" type="checkbox"/>	
Decubitis Ulcers		<input checked="" type="checkbox"/>	
Surgical Incision		<input checked="" type="checkbox"/>	
Wound Closures	<input checked="" type="checkbox"/>		LT knee open area
Tubes or Drains		<input checked="" type="checkbox"/>	
Other		<input checked="" type="checkbox"/>	

Medications:

Name	Dose	Time/Frequency	Time Last Dose Given	Special Instructions
Erythromycin	500 mg	BID		
Motrin	800 mg	TID		

Instructions:

Physician follow-up (if applicable):

Flu in wk.

Additional Comments:

Memo for bottom bunk + elevate LT. leg.

Nurses Signature: B. Cameron Lynn

00021

FIRST CORRECTIONAL MEDICAL, INC

SPECIAL NEEDS REFERRAL FORM

SPECIAL NEEDS INMATES Inmates who require close medical supervision and/or multi disciplinary care. Included among special needs inmates: chronically ill; inmates with serious communicable diseases; physically disabled; seriously mentally ill; pregnant; frail; elderly or terminally ill. Special needs considerations may be temporary (inmate needs crutches) or permanent (inmate has an artificial limb).

Date: 8-2-04 Inmate Name: Redden, Emanuel Inmate Number:

Special Need Identified by: 445m 4 N! during: Visit

Special Needs Treatment Plan Initiated: Yes No

Medical
Need: Bottom Bunk, elevated (leg), keep drsg to DK leg, clean & dry.
Expected Duration: 1 month

Housing Need:

Expected Duration:

Mental Health or Psychiatric Need:

Expected Duration:

Has durable medical equipment issued to the inmate: N Y

If yes, what equipment was used?

Was the inmate given instruction on the safe use of the equipment? Yes _____ No _____

If no,
why?

Instructions:

1. Complete the Special Needs Referral form and route to the Health Services Advisor.

***** TX REPORT *****

TRANSMISSION OK

TX/RX NO	2055	
CONNECTION TEL		8565832
CONNECTION ID	MEDIUM	
ST. TIME	08/02 08:36	
USAGE T	00'37	
PGS. SENT	1	
RESULT	OK	

FIRST CORRECTIONAL MEDICAL, INC

SPECIAL NEEDS REFERRAL FORM

SPECIAL NEEDS INMATES Inmates who require close medical supervision and/or multi disciplinary care. Included among special needs inmates: chronically ill; inmates with serious communicable diseases; physically disabled; seriously mentally ill; pregnant; frail; elderly or terminally ill. Special needs considerations may be temporary (inmate needs crutches) or permanent (inmate has an artificial limb).

Date: 8-2-04 Inmate Name: Redden, Emanuel Inmate Number:

Special Need Identified by: sean ynp during: visit

Special Needs Treatment Plan Initiated: Yes No

Medical
Need: Bottom Bunk, elevate (leg, keep airway)
Expected Duration: 1 month to (knee) clean & dry.

Housing Need:

Expected Duration:

Mental Health or Psychiatric Need:

Expected Duration:

Has durable medical equipment issued to the inmate: No Yes

If yes, what equipment was issued: **000023**